Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL MEDICAL CENTER LIVINGSTON
1201 LAKE WOODLANDS DR SUITE 4024
THE WOODLANDS TEXAS 77380

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-2170-01

MFDR Date Received
April 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Medical Center of East Texas would show that the services were rendered under an emergent basis and as such were reasonable and necessary as related to the emergent issue."

Amount in Dispute: $3,811.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is Texas Mutual's position there is nothing documented in the clinical record that reflects the sudden onset (gradual in this case) of a medical condition of sufficient severity, including severe pain (neither the nurse nor the physician documented the pain level) that without immediate medical treatment would have placed the claimant's health or bodily functions (both the nurse's and the physician's review of systems were negative except for decreased range of motion) in serious jeopardy."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 13, 2012	Outpatient Hospital Services	$3,811.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines an emergency.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Issues

1. Does the disputed service(s) meet the definition of emergency service?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?

Findings

1. The insurance carrier denied disputed services with reason code, 899 – "DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDACE WITH RULE 133.2". 28 Texas Administrative Code §133.2(4)(A) states that, "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part." The medical documentation does not meet the definition of an emergency pursuant to §133.2(4)(A). For example:
   a. EMERGENCY PHYSICIAN RECORD – onset/duration 7 days ago with gradual onset

   While the nursing record shows patient expressed a pain level of 9 out of 10 at the point of discharge, the "gradual onset" does not meet the definition of rule 133.2(4)(A). The Division concludes the denial code 899 is supported.

2. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

		September 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.